

**CANCER REPORTING IN CALIFORNIA: ABSTRACTING
AND CODING PROCEDURES FOR HOSPITALS**
California Cancer Reporting System Standards, Volume I

SUMMARY OF YEAR 2008 DATA CHANGES

This document will provide a summary of data changes for 2008 for hospitals, abstracting vendors, and regional registry data collectors. The changes to Volume I will be available in March 2008. This document is divided into sections – Additions (New Data Items) and Changes (Revised Data Items).

ADDITIONS (New Data Items):

Address DX City USPS

This is a generated data item that identifies the city in which the patient resides at the time the reportable tumor is diagnosed.

Rationale: Currently the city at diagnosis name in the NAACCR record layout is 20 characters. We are running into city names that are getting truncated. The USPS file listing allows up to 28 characters. They do have approved abbreviations for some longer names but not all of them. This new field would accommodate cities that are more than 20 characters. *No data entry required, as it is a generated field.*

Code: Generated - 28 characters (letters and spaces)

DxRx Report Facility ID (1-5)

DxRx Report Number (1-5)

DxRx Report Date (1-5)

DxRx Report Type (1-5)

Rationale:

The CCR is revising its central system (Eureka) to tightly integrate pathology report processing with new case abstract processing, and it needs a way to easily match abstracts to path reports. Thus, five sets of path report identifier data items will be added to the CCR's required data set expected in new cases to allow the documentation of up to five pathology reports that were used as reference reports by the abstractor. These new items include "DxRx" in their names because they are intended to allow documentation of diagnostic and treatment reports, but initially they will be used to document the types of pathology reports used in abstracting that are listed below under DxRx Report Type. Additional report types that include report numbers, dates, and facilities may be added later as they become available.

Advantages:

- More space to enter path report data

The existing pathology text field and the two existing biopsy and surgical path report number fields frequently do not provide enough space to record all the relevant pathology reports and their results for all cases. By creating separate fields for up to 5 report numbers and specimen dates, abstractors will not have to use other unrelated fields for overflow text as often, it will be easier to record all reports referenced.

- Clear identification of path reports referenced

Since the CCR/regional registries will be changing the visual editing process to review submitted abstracts with their associated path reports, it will be important to make sure all path reports referenced are clearly identified, and these additional data items will make that easier.

DxRx Report Facility ID 1-5

Identifies the facility that produced the report, using the CCR reporting source number.

Note: Eventually, this may become the NPI number for the facility, but for now we will use the CCR reporting source numbers.

Code: CCR reporting source number; blank for cases diagnosed prior to 01/01/08

Field length: 10 characters

DxRx Report Number 1-5

Filler order number/lab accession number associated with the pathology report specimen or other report type's number uniquely identifying the report for that facility. For cases diagnosed prior to 1/1/2008, this field will be filled with data converted from the following fields: Pathology Report Number Biopsy/FNA and Pathology Report Number Surgery.

Code: Filler order number/lab access number

Field length: 20 characters

DxRx Report Date 1-5

Date the specimen associated with a pathology report was collected from the patient, or the most distinguishing report date for other document types.

Code: Valid date or blank for cases diagnoses prior to 01/01/08.

Field length: 8 characters

DxRx Report Type 1-5

Identifies the type of report entered as a reference report in the other DxRx fields of the set.

Codes:

- 01 Biopsy
- 02 Surgical resection
- 03 Bone marrow biopsy
- 04 Autopsy
- 05 Cytology
- 06 Flow Cytometry/Immunophenotype
- 07 Tumor Marker (p53, CD's Ki, CEA, HER2-neu)
- 08 Cytogenetics
- 09 Immunohistochemical stains
- 10 Molecular studies
- 88 Other, NOS

Blank is allowed if there is no report or if the diagnosis date is prior to 01/01/2008.

Field length: 2 characters

Note: Additional codes will be added as other sources become available.

Over-ride Flag Hospital Sequence/Site (NAACCR # 1988)

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

Seq Num--Hosp, Primary Site, Morph ICDO2 (CoC)

Seq Num--Hosp, Primary Site, Morph ICDO3 (CoC)

Rationale: This is a data item was added to be consistent with NAACCR. Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Codes:

1 Reviewed

Blank Not reviewed or reviewed and corrected

Field Length: 1 character

Text – Staging (NAACCR # 2600)

Additional text area for staging information not already entered in the Text--DX Proc areas.

Rationale: Currently, this field is available, but not transmitted to the CCR by software vendors. Abstractors can now use this field to document additional staging and diagnostic workup information.

Field Length: 300 characters

Rad-Location of RX (NAACCR #1550)

Identifies the location of the facility where radiation treatment was administered during the first course of treatment.

Rationale: Currently, the only mechanism for verifying that radiation was given at the reporting hospital is through review of text. If these were coded fields, correctly distinguishing between Class 0, 1, 2 and/or 3 could be accomplished automatically rather than requiring review of text.

Codes:

- 0 No radiation treatment
- 1 All radiation treatment at this facility
- 2 Regional treatment at this facility, boost elsewhere
- 3 Boost radiation at this facility, regional elsewhere
- 4 All radiation treatment elsewhere
- 8 Other, NOS
- 9 Unknown

Note: This item is in abstracting software for use by ACoS approved facilities. This will require non-ACoS facilities to start collecting a new data item. This field is currently required in CNEXT to calculate Radiation at this Hospital.

Field Length: 1 character

CS Tumor Size/Ext Evaluation (NAACCR # 2820)

Records how the codes for "CS Tumor Size" [2800] and "CS Extension" [2810] were determined based on the diagnostic methods employed.

This data item is used in CS to identify whether the T (of AJCC TNM) was clinically or pathologically diagnosed and by what method, "CS Tumor Size/Ext Eval" is used to derive the Derived AJCC T Descriptor [2950].

Rationale: SEER requires the collection of this data item beginning with cases diagnosed 1/1/2008 forward.

Codes:

See the most current version of the *Collaborative Staging Manual and Coding Instructions*, for site-specific codes and coding rules.

Field Length: 1 character

CS Reg Node Evaluation (NAACCR # 2840)

Records how the code for the item “CS Lymph Nodes” [2830] was determined based on the diagnostic methods employed.

This data item is used in CS to identify whether the N (of AJCC TNM) was clinically or pathologically diagnosed and by what method "CS Reg Nodes Eval" is used to derive the Derived AJCC N Descriptor [2970].

Rationale: SEER requires the collection of this data item beginning with cases diagnosed 1/1/2008 forward.

Codes:

See the most current version of the *Collaborative Staging Manual and Coding Instructions*, for site-specific codes and coding rules.

Field Length: 1 character

CS Mets Evaluation (NAACCR # 2860)

Records how the code for the item “CS Lymph Nodes” [2830] was determined based on the diagnostic methods employed.

This data item is used in CS to identify whether the N (of AJCC TNM) was clinically or pathologically diagnosed and by what method "CS Reg Nodes Eval" is used to derive the Derived AJCC N Descriptor [2970].

Rationale: SEER requires the collection of this data item beginning with cases diagnosed 1/1/2008 forward.

Codes:

See the most current version of the *Collaborative Staging Manual and Coding Instructions*, for site-specific codes and coding rules.

Field Length: 1 character

CHANGES (Revised Data Items):

Pathology Report Number Biopsy/FNA

This data item becomes obsolete with the implementation of DxRx Report Number. Convert this data item to the new field -- DxRx Report Number 1.

Pathology Report Number – Surgery

This data item becomes obsolete with the implementation of DxRx Report Number. Convert this data item to the new field -- DxRx Report Number 2.

Religion (NAACCR # 260)

Add code 94 - Scientology

State Code Abbreviations (NAACCR # 1820)

Add the following postal codes for active US military personnel serving abroad:

AA American Territories

AE Europe

AP Pacific

Last Type of Patient Follow up and Reporting Source Number

Add new code to Last Type of Patient Follow Up – Research Study Follow Up. Add Reporting Source Number and label for Research Study Follow Up code.

Rationale: This code and label are needed in order to identify follow up information provided from research studies.

Codes:

Last Type of Patient Follow up:

48 Research Study Follow Up

Reporting Source Number: 0448